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ROYAL COMMISSION OF INQUIRY INTO CERTAIN DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange	Commissioner
P.S.A. Lamek, Q.C.	Counsel
E.A. Cronk	Associate Counsel
Thomas Millar	Administrator

Transcript of evidence
for

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND RELATED MATTERS.

Hearing held on the 8th Floor, 180 Dundas Street West, Toronto, Ontario, on Thursday, the 22nd day of December, 1983.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner

THOMAS MILLAR - Administrator

MURRAY R. ELLIOT - Registrar

APPEARANCES:

E. CRONK	Commission Counsel
D. HUNT) L. CECCHETTO)	Counsel for the Attorney General and Solicitor General of Ontario (Crown Attorneys and Coroner's Office)
I. ROLAND) R. BATTY)	Counsel for The Hospital for Sick Children
D. YOUNG	Counsel for The Metropolitan Toronto Police
K. CHOWN	Counsel for numerous Doctors at The Hospital for Sick Children
F. KITELY	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children

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---Upon commencing at 10:00 a.m.

THE COMMISSIONER: Yes, Mr. Tobias.

MR. TOBIAS: Good morning, Mr. Commissioner.

CAROL BROWNE, Resumed

MR. TOBIAS: Before I begin my questions of this witness, sir, I just wish to state for the record that I do adopt the position taken yesterday by Mr. Labow and Mr. Hunt regarding the statement.

THE COMMISSIONER: Yes.

MR. TOBIAS: And I don't want to repeat those submissions because I think that they succinctly stated what my concerns are as well. But I don't wish to take my proceeding with this cross-examination as any type of waiver.

THE COMMISSIONER: No.

MR. TOBIAS: Once I see the statement I, indeed, as Mr. Labow may have no questions whatsoever. However, should I have such questions I would expect that this witness would be recalled, or I will at least make that request of you, sir.

THE COMMISSIONER: Yes. I want to tell you it is not this statement that worries me. It is other statements that worry me and I doubt

A2 very much after all the fuss we have made about this statement that anybody will have any questions, but it is possible and it is something that I'm going to think about.

Before I forget and before you start though some people may not be aware, we are not going to sit on the 9th; we are going to start on the 10th of January. We may have to sit on what I have now discovered is Friday the 13th. So, it may be an unlucky day for us. We will just see how we get along and we may have to make up for it. We obviously will not be sitting on the 16th when the stated case will be dealt with in the Divisional Court. Even if it should go over to the second day we will plot to go on that day and we will hope that we will arrange our lives that we will be able to do that.

The Registrar has given me a note "Counsel should be advised that all tables must be completely cleared of books, et cetera, so the tables may be repaired over the Christmas break."

So, could I ask you to do that at the end of the day; if Mr. Tobias and Ms. Cronk and Ms. Kitely will complete in time we may even be able to do that this morning.

MR. TOBIAS: I will give you my utmost co-operation, sir.

THE COMMISSIONER: Yes. I have an instrument now that I can make use of.

MR. TOBIAS: I understand that it is a timely instrument, sir.

CROSS-EXAMINATION BY MR. TOBIAS:

Q. Ms. Browne, my name is Warren Tobias and I act for the family of Jordan Hines. I would like to start by asking you some questions regarding the meeting of March 11th, 1981 in which you advised Ms. Cronk about. I believe the other day in giving your evidence on December 20th, 1983, you indicated that you couldn't recall who it was that had called that particular meeting. I would like to know if it assists you at all if I suggest to you that it may have been Susan Reaper, does that at all jar your memory?

A. No.

Q. All right, fine. Now, you also indicated that you couldn't be sure who it was that attended that meeting. I would like to ask you again, was Susan Reaper in attendance to your knowledge?

A. I'm sorry, I can't remember.

Q. All right. You are familiar

with Meredith Frise?

A. Yes.

Q. Do you recall whether she was in attendance at that meeting?

A. No.

Q. Fine. Now, you also indicated to Ms. Cronk the other day that the nature of the concern that was expressed at the meeting was that the death of Jordan Hines was unexpected. I wonder if you might comment on that. Why was it unexpected, what was the consensus of opinion as to why it was unexpected?

A. I can't recall specifically except that things had happened quickly and, again, the nurses' perception of the child's condition on admission was not such that they felt that it would result in his death.

Q. All right. Is it fair to say in fact then that it was felt that the death was unexpected given the clinical picture of the child and how he was doing on the two days that he was in the Hospital prior to the arrest?

A. And could I add to that and the nurses' awareness of that clinical picture.

Q. All right, fine. Now, I'm

not sure if you have had an opportunity to review the medical chart of Jordan Hines but is it also fair to say that one of the things about that clinical picture was the absence during those two days of any apparently life threatening events?

A. To my knowledge I haven't reviewed the medical history.

Q. All right, fine. Now, you also indicated to Ms. Cronk, and the specific question was:

"Was there something in the timing of his death per se that concerned the nursing staff."

And your answer was:

"I think it was sudden."

What I would like to know is this. Was that the consensus expressed at that meeting?

A. That it was sudden?

Q. Yes.

A. I believe so, yes.

Q. All right. Were there any members of the nursing staff at that meeting who expressed a contrary view who were not surprised and who did not feel that the death was unexpected or sudden?

A. Not that I remember, no.

Q. Is that something that you would be likely to remember had a contrary opinion been expressed?

A. At this point in time I'm not sure.

Q. All right, that's fair enough. You were also asked whether there was any concern expressed by a particular member of the nursing staff. Now, you have indicated that you don't recall at all whether Susan Reaper was at the meeting. What I would like to know is this. At any time prior to or after the arrest of Jordan Hines do you recall any discussion with Susan Reaper particularly wherein she expressed concern to you over the suddenness of the terminal event?

A. I don't recall her specifically, no.

Q. All right. So, you have no independent recollections of any particular discussions with her at any time concerning the death of Jordan Hines, is that correct?

A. That is correct.

Q. All right. Now, you were also asked the other day whether or not there was a

discussion at that meeting regarding the death of any child other than Jordan Hines and I believe that you said 'not that I remember'. Now, I have a concern about that and it is as follows. It seems to me that the Jordan Hines death occurred after a series of deaths which would have transpired between the January meeting and the March meeting, the March 11th, 1981 meeting.

A. Yes.

Q. And it seems to me that the meeting was called, according to the minutes kept in the 4B meeting book, after the death of Jordan Hines. Do you find anything curious or anything in particular about the death of Jordan Hines that would have caused that particular death to trigger the meeting? Why not meetings after other deaths, why Jordan Hines?

A. I can't say that there weren't meetings after other deaths. I think the reasons that have already been stated this morning why there was a meeting particularly after the death of Jordan Hines.

Q. Surely you are not indicating though that there were not other deaths in the intervening time period that had an element of

suddenness or unexpectedness or surprise?

A. Would you ask that again please.

Q. I say surely you are not suggesting that during the intervening period between the January meeting and the March meeting that there were not other deaths on the ward which had elements of surprise and unexpectedness?

A. I'm not saying yes or no to that. What I am saying is that other deaths may indeed have stimulated nursing coming together and talking about those deaths.

Q. All right. In any event though in the Ward 4B meeting book there are no notations of meetings between January and March?

A. That is correct.

Q. I take it therefore that if there were such discussions and meetings they were ad hoc and not in any way formal?

A. I would agree.

Q. All right. Now, I do find it curious and I want to know whether you find it curious that it was the death of Hines that triggered the next formal meeting.

A. I don't know that I find it so curious. Some of our meetings were informal and

if needs were met informally then we didn't necessarily have a formal meeting. I think in the review of the communications books and the ward meeting books it was evident the difficultly around scheduling formal meetings within ward time.

Q. All right, let me ask you this question. I am suggesting to you that notwithstanding what you told Ms. Cronk the other day and what you have told me this morning about the particular death of Jordan Hines, there was really nothing so striking or so odd about that death to distinguish it from other deaths that it would stand out. It seems to me that perhaps the reason why a meeting was called after the death of Jordan Hines was in fact the cumulative effect of a number of deaths. What I'm suggesting to you, this may have been the last straw. Do you think that had anything to do with the meeting being called following that death?

A. Because my memory is vague I would have trouble responding to that.

Q. All right, let me move on.

If other deaths had been discussed at that meeting, do you not agree with me that it is likely that a note would have been made of that in

the Ward 4B meeting book?

A. I would expect so, yes.

Q. Clearly the only reference being to Jordan Hines I think it is safe to assume, do you not agree, that at that particular meeting his death was the only death discussed?

A. I would assume that.

Q. All right, fine. Now, you also indicated the other day that you didn't remember whether or not there was any other concern or matter raised regarding the death of Jordan Hines at that meeting and that you couldn't recall whether any decision was taken at that meeting to pursue the matter further or to discuss the matter with any member of the cardiology staff. If such a decision had been taken as a result of a meeting that a joint decision be made, would it not have been you as the liaison person who would have approached the staff member, the cardiology member?

A. Not necessarily, it very well may have been the head nurse.

Q. All right. Might it have been anyone other than you or the head nurse?

A. Generally that's where it would have been delegated.

Q. All right, fine. You also said that you did believe that it was subsequent to the meeting brought to the attention of the cardiology staff. To quote you when that question was put to you you said 'I believe so'. Do you know or do you have any information as to which member of the cardiology staff that concern was raised with?

A. I can't recall.

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Q. Do you recall at or near this time, or in the time immediately following, whether there was any effort made to your knowledge, to your direct knowledge, by any of the cardiologists or the cardiology staff to meet with the nurses to discuss this particular death in order to explain the circumstances to them, and in order to in effect answer the concerns which had been expressed?

A. Again, I am sorry, I can't remember.

Q. May I suggest to you that had that happened, in other words the concern that had been expressed to the cardiology staff triggered a response by that staff wherein they met with the nurses that would have been something that you likely would have either made a note of in the 4B meeting book, or would have recalled, is that fair?

A. I think that is fair.

Q. I think we can fairly assume from that that there probably was not such a subsequent meeting initiated by the members of the cardiology staff, do you agree with that?

A. Could I qualify in terms of there being a formal meeting?

Q. All right, you can qualify to

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that extent. Do you agree with that observation as it relates to the holding of a formal meeting?

A. Yes.

Q. Regarding the normal routine for the administration of drugs for children on Wards 4A/4B for the period with which we are dealing, I note that in the medical record of Jordan Hines there appears to be a medication record and flow chart, and I will direct your attention to page 83 of that record. We are dealing now with the medication and treatment record of Jordan Hines.

Now, at the time that the child is in the Hospital being treated, can you tell me where does this record appear, where is it kept, is it at the nurses' station, is it in the child's room at the foot of his bed, can you tell me where it is located?

A. It is located in the child's chart which is kept at the nurses' station.

Q. Now, it is obvious from the reading of the chart that there are certain dates which medications are ordered, and then there are instructions and times given. Then I take it that the writing which appears to the right of the time column indicates at which time the prescribed drug

is administered and a signature is required, and I take it that is the signature of the nurse who administered the drug?

A. That is correct.

Q. Now, in the ordinary course would the nurse take the child's chart to the room with her when she was administering the drug, or would the chart stay at the nursing station?

A. It would stay at the nursing station.

Q. When would these entries be made?

A. They might be made right after the medication was given. If it was a busy day they might not be made until lunch time or the end of the shift.

Q. Now you say in the first instance that they might be made right after the medication is given. I take it that each nurse is responsible for more than one child in terms of administering drugs?

A. That is correct.

Q. Now, we know that not all children on the ward or in a particular room would be receiving the drugs, or their particuar drugs at the same time?

A. That is correct.

Q. You agree with that?

A. Yes.

Q. But is it safe to assume that in the ordinary course that you would be administering drugs at one given time to more than one child?

A. She may very well be, yes.

Q. Can you tell me from your experience, typically, how many children she might be administering drugs to at a given time?

A. Four or five.

Q. Now, in your earlier answer to me that these entries may be made immediately after the medication was given, I assume from that that what you mean is the entry is made after she is finished administering the drug to the four or five children?

A. That is correct.

Q. Now assuming that there is a drug error; and I am asking you to assume that digoxin prescribed for Baby A is given inadvertently to Baby B. Do you not agree with me that if there was no obvious errors in the medication and treatment record we would need two mistakes, we would need first the mistake in giving the drug and yet she would have

to go back and enter the administration of digoxin on the chart of Baby B, the baby it had been intended for?

A. That is correct.

Q. So that you would have to give it to A and then when you go back to the room a few moments later, to the nursing station, mark down the administration to Baby B?

A. Yes.

Q. Now, do you have any opinion, from your own personal experience, as to the likelihood of that kind of double error occurring?

A. Well, if I could refer you to the information that I prepared and was circulated on Tuesday. If indeed the nurse does check the medication card against the child's identification band, and that is the only way of identifying a baby because they certainly can't tell you their names, if indeed that is done the likelihood of giving the medication to the wrong patient is eliminated.

Q. I am sorry, Ms. Browne, I missed the last part of that response, I did not hear you?

A. If the medication card is checked against the patient's identification card

and identification band which would be on the wrist or the ankle, which is the only way of identifying a baby since they can't tell you their names, if that is done that eliminates the possibility of giving the drug to the wrong patient.

Q. Would that not be done as a routine matter?

A. Yes.

Q. So that - I am sorry, you have helped me out a little bit, because now it would appear that we would have to have three things go wrong: (a) that they don't check the identification; (b) that they then not having checked indeed give the drug to the wrong baby; (c) they still go back to the nursing station and indicate the administration in the right chart.

Now I ask you again, do you think on the basis of your experience in nursing that that is a very likely scenario?

A. It is a possible scenario.

Q. I concede it is possible. The question was, is it a likely scenario?

A. Not indeed if you follow standards and policy, no.

Q. And do you agree with me that

the more times you postulate that kind of error being repeated the less likely it becomes. My point being it can happen once; it can happen twice; it becomes extremely tenuous to suggest that it might happen five, six or seven times?

A. Yes.

Q. Now, I would also like to ask you about this possibility; if indeed the entries on the medication treatment record were not made after the administration of the drug, perhaps the nurse gets busy and doesn't get around to it until lunch time, is it likely in your view, is it probable, I am going to use that word, that from time to time perhaps a drug is administered and it is not recorded in a child's chart at all?

A. That happens.

Q. Can you tell me what kind of safeguards or procedures were in place during the period in which we are interested, to try and eliminate that from happening?

A. The charts were reviewed on a fairly regular basis by the head nurse to note just that, if indeed there were medications that were not signed off, and if so, why not, was it that the medication was not given or was it that the nurse

did not sign them off after having given them?

Q. I take it on a given day a given nurse would be assigned the responsibility for administering particular drugs to particular children?

A. That is correct, for her time of duty, yes.

Q. And if the head nurse on that day reviewed that particular chart and noted no entry, I take it she would then question that particular nurse as to (a) was the drug given, and if not, why not?

A. Yes.

Q. And this was done on a fairly regular basis by the head nurse?

A. Yes.

Q. As part of her day-to-day responsibilities?

A. Yes.

Q. I take it you were satisfied at the time that that was an effective safeguard?

A. Yes.

Q. So again I suggest to you that it is not all that likely that on a regular basis drugs were administered without being recorded on the treatment record?

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A. Can I say yes but qualify that?

Q. You certainly may.

A. Having reviewed some of these charts in the last week or so, indeed there were instances where medications were not signed off, where the area next to the time notation was circled to indicate that no signature had been done.

Q. All right. I think this is a fair question and I am sure Ms. Kitely will slap my wrist severely if it is not. You say that having reviewed the charts recently you note instances where that happened?

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Do you have enough concern today that if you felt that was still happening you would raise that issue and perhaps change the system you have in place for safeguarding against that happening?

A. Would you repeat that question, please?

Q. I will.

THE COMMISSIONER: And you had better not answer it for a moment.

MR. TOBIAS: I think what the Commissioner is indicating is you should give your counsel and Ms. Cronk an apportunity to fence with me before you ---

MS. CRONK: I am here, Mr. Tobias. My recollection of the witness' evidence is that she is no longer at the Hospital for Sick Children, and if the inference is to be drawn that she has some ability to influence the events of the Hospital now, perhaps it is an unfair question.

MR. TOBIAS: That was indeed not my inference. May I perhaps clarify the question.

Q. If we could go back now to July of 1980 and if you reviewed the charts and you saw some of these omissions, it being July of 1980, would you see them with such regularity, in other

C2

words, would your concern over the omissions that you have noted cause you to raise that question and think about perhaps changing the system because the system itself was inadequate?

A. Well, could I say that the charts that I reviewed were charts that were random charts, if you will, over a nine month period. So it is hard for me to then say on a monthly basis what that would be.

I can say in the time period you are referring to in terms of July I was not aware of an increased incidence of medications not being signed off.

Q. In any event, we can agree on one thing. Between July of 1980 and March of 1981 nothing was done to alter or change or modify the system that you have just described to me?

A. Not that I was aware of.

Q. So as far as the nursing staff at the Hospital was concerned at that time it was an adequate system?

A. Yes.

Q. Now, you also told Mr. Hunt yesterday, I believe, and please forgive me, I do not have the specific page reference having been

C3 preoccupied with other things last night than reading the transcript, but ---

THE COMMISSIONER: That is no excuse at all.

MR. TOBIAS: Q. But I believe that I am fairly summarizing the evidence when I say that you told Mr. Hunt that there was an element of surprise with respect to two deaths, and you mentioned Dawson and Gage. Do you recall giving that evidence?

A. Yes.

Q. Now, I find that somewehat curious because of the evidence that you gave me earlier and that you gave Ms. Cronk. I thought you had said that the Hines death was unexpected. Can we also agree that it was somewhat of a surprise?

A. Yes.

Q. Just to give you the opportunity to clarify this for the record, are you now saying that there was indeed more than two deaths with an element of surprise? Would you include Hines in that group of two, thus making it a group of three?

A. I would.

Q. Thank you. I understand that it was part of your function to deal with the parents

C4

of these children?

A. That is correct.

Q. In effect, you were a liason person?

A. Yes.

Q. In fact, you have special training and qualifications for dealing with parents at times of stress such as these parents obviously must have been going through?

A. Yes.

Q. I also understand there was another colleague of yours, is it Janice Beed; have I got that name correctly?

A. Yes.

Q. Who also dealt with parents?

A. That is correct.

Q. During the time that you were at the Hospital did you have any dealings at all with Mr. and Mrs. Hines?

A. No, I did not.

Q. Do you know, to your knowledge, if Janet Beed had any dealings with them?

A. I do not believe so, but I may not be totally accurate in that period.

Q. Are you at all familiar with

C5 their particular case from the point of view of their reaction to their child's death, the questions that they raised, the concerns that they expressed?

A. Not in any detail, no.

Q. Well, let me assist you just a little bit. There has been evidence given before this Commission by Dr. Fowler to the general effect that in fact the Hines were quite vigorous in trying to stay in contact with people at the Hospital and seeking out answers to questions, that they pursued Dr. Fowler, they pursued Dr. Costigan. Obviously you were not aware of that at the time?

A. No.

Q. And obviously, I take it, because you said you never had any dealings with them, no one at the Hospital referred these people to you or asked you to contact them to help them?

A. That is correct.

Q. Do you know whether anyone at the Hospital would have asked Janet Beed to contact them or to deal with them?

A. I cannot really say.

Q. I would also like to ask you about the events of the weekend of March 23rd, 1981. I am referring specifically to the time when digoxin

C6 became a controlled drug. I think you can agree with me that from a nursing standpoint that is a rather severe step, is it not?

A. I do not know that severe would be my word, but it is a significant step.

Q. All right. Something that certainly would not go unnoticed or escape the attention of the staff.

A. True.

Q. I would like to know whether on that weekend, and it is quite obvious to me that you were in ongoing contact with the nursing staff on 4A/4B, there had been numerous discussions, concerns raised over the events on the ward. Was there any discussion at that time in March of 1981 with respect to the reaction of the nursing staff to the news that digoxin had become a controlled drug?

A. I was not on the ward that weekend so I cannot speak to reaction at that point in time. I can tell you that on the Monday when I came on, nurses indeed were reacting to that and felt that it was a reflection of a lack of trust, that they were not able to perform their duties as they had before.

Q. All right. Now, was there any

C7 particular member of the nursing team that you can recall raising that particular concern about a lack of trust with you?

A. I do not remember one person specifically, no.

Q. Now, is the reason that you do not remember one specific person because they all raised that issue or is it just lack of ability to specifically recall right now?

A. My recollection is that it was all of the RNs that raised that concern. They felt they were being watched.

Q. Did you discuss that question with particular vigor with any particular member of the nursing staff?

A. Not that I recall, no.

Q. Do you recall if any particular member of the nursing staff was or more less vociferous and vigorous in expressing that concern to you? Does anyone's reaction particularly stand out?

A. No.

Q. All right. You also, I believe, indicated to Ms. Cronk in your examination in chief that after Susan Nelles was discharged in retrospect you considered the global picture of what had

C8

happened and looked at these deaths, and there was evidence that statements were made to the effect that all of the deaths could not be explained by natural causes. Now, I do not want to go into that in the same way that Ms. Cronk did, but I would like to ask this question: what was your feeling about that very issue, the cause of death globally, with respect to the whole series of transactions and whether or not it could be explained by natural causes not after the preliminary inquiry but when you first became aware that a nurse had been charged?

A. It was disbelief.

Q. Shock?

A. Yes.

Q. Did you have a view at that time in your own mind as to whether these deaths could be explained by natural causes?

A. Did I have a view that the deaths could be explained?

Q. Did you have a view at that time as to whether or not they could be explained by natural causes, and if you did, could you tell us what that view was?

A. My view was that indeed the deaths could be explained by natural causes.

Q. Are you indicating to me that the charging of a nurse did nothing to shake that belief, to qualify it?

A. Not at that time, no.

Q. Finally, I would like to ask you about the relationship of two particular nurses during the time with which we have been dealing. I believe that you have given some evidence regarding alleged instances of tension between Susan Nelles and Phyllis Trayner?

A. That is correct.

Q. I believe that you indicated -- please correct me if I am wrong -- to Mr. Young that you were not aware of any particular instance of tension that would have raised any concern regarding their professional judgment and the care they were rendering to the patients; do you recall that evidence?

A. That is correct, yes.

Q. So I take it obviously you have no prior knowledge of any significant tiffs between the two of them which would have interferred with the patients?

A. That is correct.

Q. All right. Now, it is my

C10 understanding and my information that Meredith Frise gave evidence at the Preliminary Inquiry, and Mr. Commissioner, you will find two references ---

MR. BROWN: Mr. Commissioner.

THE COMMISSIONER: Yes.

MR. BROWN: I understand that Mr. Tobias is going to make reference to the evidence of Nurse Frise which was given at the Preliminary Inquiry. Ms. Frise indeed in her evidence does deal with an incident occurring during the death of Baby Hines. It is my understanding that this witness was not present at the Hines' arrest nor the time of death.

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And as a matter of principle I take exception at this point in time to the procedure which I believe Mr. Tobias is going to adopt.

THE COMMISSIONER: Well, I wonder if we can resolve this because it may be that the witness has no knowledge of what it is. What is the nature of your question? Can you tell me the nature of your question without disclosing what the evidence was at the preliminary inquiry?

MR. TOBIAS: Certainly.

Q. Are you aware of an incident which happened during the Hines' arrest, during the arrest itself, during the resuscitation efforts, wherein Trayner and Nelles were engaged in quite a heated argument over what kind of pacemaker to use on Baby Hines?

THE COMMISSIONER: Can I just ask first of all, were you present at the time?

THE WITNESS: No.

THE COMMISSIONER: No. And this evidence that you can give can only be given by, I take it - first of all, do you know anything about it?

THE WITNESS: No.

THE COMMISSIONER: No, you don't?

THE WITNESS: No.

D.2

THE COMMISSIONER: Doesn't that solve our problem?

MR. TOBIAS: Well, it does and it doesn't, Mr. Commissioner. May I tackle it this way.

THE COMMISSIONER: All right.

MR. BROWN: I would like to make some submissions to you, Mr. Commissioner.

THE COMMISSIONER: Well, let's hear what he is going to do because it may not affect you at all.

MR. TOBIAS: What I in fact was going to do, being concerned for fairness, was in fact to put to the witness not Mr. McGee's examination in chief but in fact Mr. Cooper's cross-examination. It becomes apparent --

THE COMMISSIONER: Could I see it?

MR. TOBIAS: Yes.

THE COMMISSIONER: Could I see what it is?

MS. FORSTER: I wonder if Mr. Tobias could give us the page references as well?

THE COMMISSIONER: Yes, all right.

MR. TOBIAS: I was about to. I am dealing with Volume 17 and the exchange which starts at page 70 and it goes on to approximately page 81.

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I'm sorry, I'm on the original page reference, 78 to 81.

THE COMMISSIONER: All right, thank you.

MR. TOBIAS: Perhaps you can have a look at that, Mr. Commissioner.

THE COMMISSIONER: Could I just have some indication who Nurse Frise was?

MR. TOBIAS: I believe, Mr. Commissioner, she is a registered nursing assistant who was part of the arrest team on the evening that Jordan Hines went into arrest.

THE COMMISSIONER: Yes, all right, thank you.

MR. KNAZAN: That is Ms. Solomon's client who I am standing in for; Ms. Frise.

THE COMMISSIONER: Oh, oh yes, I see, I beg your pardon, one of the many, one of the many, yes.

MR. KNAZAN: That is correct.

MR. BROWN: Mr. Commissioner, if I might?

THE COMMISSIONER: Yes.

MR. BROWN: Notwithstanding that Mr. Tobias says that he is concerned with fairness he is prepared to read Mr. Cooper's cross-examination.

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I mean, I don't care whether or not it is Magee's examination or Cooper's cross-examination, that's not the point. The point is that the witness has already established that she was not present at the time of the child's death, nor does she have any personal knowledge of the alleged incident.

THE COMMISSIONER: Yes.

MR. BROWN: I don't think that counsel in this forum should use witnesses who lack personal knowledge as a conduit to make statements which can be brought out from the personal knowledge of other witnesses. If that witness has to be called, so be it, but I am in an impossible position to cross-examine. All I can do is read what is in the transcript.

THE COMMISSIONER: Yes.

MR. BROWN: You did not appreciate the re cross-examination I did yesterday, nor do I want to be put in that position. To avoid that I don't think that this sort of examination is proper. If he wants to ask something about what Ms. Frise saw, let's call Ms. Frise.

THE COMMISSIONER: Yes. I wonder if I could just read it though so I will at least know what the subject of this debate is, which I don't at the moment.

How far do I read down the page?

MR. BROWN: Page 83, Mr. Commissioner.

MR. TOBIAS: Page 82, Mr. Commissioner.

I don't take umbrage, nor do I particularly disagree with the submissions made by my friend Mr. Brown. It is not my intention to put into evidence the facts concerning whether or not this incident happened. I agree with him, if I want to cross-examine on that particular point I am free to put the particular scenario to Ms. Frise or to the participants in the particular debate that you have just read about.

I am merely intending to put the scenario to Ms. Browne so I can ask her this. If in fact the description of the event is accurate, assuming that as a given, as a hypothesis, is that not in effect one instance where it is obvious that tensions on the floor did interfere with the professional judgment of some of the nurses and the level of competence with which they discharged their duties. I can only ask that of this witness because she has given evidence that to her knowledge that was not interfered with. So, it is going to be too late to ask Ms. Frise or Ms. Trayner or Ms. Nelles. I want this witness' opinion on whether

or not that type of incident does impair,

THE COMMISSIONER: It could all have been done by a hypothesis. If this sort of situation existed, without mentioning any names at all, would you consider that to be unprofessional conduct, or whatever the question was. Unfortunately, we have now got so deeply into it.

MR. TOBIAS: Yes.

THE COMMISSIONER: With the names that it may be impossible to do it any more. But that would have been, I would have found, totally unobjectionable.

Yes, Mr. Olah, you have something to say?

MR. OLAH: Well, I would like to take objection to this kind of procedure because we have now seen in two incidents yesterday with Mr. Young and today with Mr. Tobias where obviously evidence which the witness in the box can't relate to because she wasn't there and has no knowledge of it.

THE COMMISSIONER: She can give as a senior nurse her opinion on conduct.

MR. OLAH: No question about that.

THE COMMISSIONER: That should or

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should not take place.

MR. OLAH: No question about that, Mr. Commissioner. But what we are getting is via the back door evidence that shouldn't be admissible and I strongly object. With the greatest of respect, we are setting a very dangerous precedent.

THE COMMISSIONER: Well, no, it would be perfectly legitimate had it been put that way and I'm just wondering whether it can still be put that way, that's all.

MR. TOBIAS: I think it can be, Mr. Commissioner, and I'm prepared to proceed in that manner.

THE COMMISSIONER: Yes, without any names being mentioned, is this appropriate?

MR. BROWN: It is not a matter of naming names. It is the transcript of the preliminary inquiry, it is a matter of public record, the incident is there and it can be brought out through the appropriate witness.

What I'm objecting to is that it is unfair to a witness to have this put to her in that way when she has no personal knowledge of the matter.

THE COMMISSIONER: No, no, this is expert evidence. That is expert evidence, is that appropriate.

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MR. BROWN: Precisely, if you do it by a hypothesis. But that is not the way that Mr. Tobias was going to proceed.

THE COMMISSIONER: I'm sorry, yes.

MR. TOBIAS: Well, are we now objecting to the manner in which counsel was going to proceed after counsel has indicated he no longer intends to proceed that way?

THE COMMISSIONER: That's right, you don't. If you want to put a hypothetical question, and it is purely hypothetical without any names being put to this witness as an expert witness in nursing practice as to whether that is appropriate conduct on the part of nurses I can't really stop you from doing it, but I want you not to mention any names at all. The time may come when you can mention names but you can't mention them now because I take it you were not present at the resuscitation attempts with Jordan Hines.

THE WITNESS: That is correct.

THE COMMISSIONER: You don't know anything about it. Well, I will hear your objections but there can't really be any objection to that kind of question.

MR. BROWN: I have no objection to that

and certainly in anticipation of the second patient, Amber Dawson, there is another incident that Mr. Tobias wants to go into I imagine and again if it is put in the situation of a hypothetical, asking for an expert opinion, that's fine.

THE COMMISSIONER: Okay. Yes, Mr. Young, you want to participate in this?

MR. YOUNG: Yes, I hate being left out. A brief comment, Mr. Commissioner. This witness has come to us and I have the greatest respect for her, she has come to us and told us that she was in the Hospital largely to look after problems just like the one Mr. Tobias is putting to her. If indeed there was a problem during the attempted resuscitation of this baby, I don't think it is impossible for that problem to be put in front of her at a later date. If she did, then she may have evidence as to what Ms. Nelles, who we haven't heard a great deal from, or Ms. Trayner said to her at that time and that would be of great importance. She said she wasn't at the resuscitation but it would seem quite logical that she might have investigated it or at least discussed it with the individuals to reduce stress.

THE COMMISSIONER: Well, I suppose we could ask her that question now. Did you take any

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action at any time with respect to a report relating to something that took place at the Hines' resuscitation?

THE WITNESS: Not that I remember.

THE COMMISSIONER: Do you remember even having this matter reported to you at the time?

THE WITNESS: No.

THE COMMISSIONER: Well, that I think solves that problem. Now, the next thing is, I want you to put a purely hypothetical question. If certain facts took place, and I want all counsel to realize a hypothetical question is only as good as the truth of the facts upon which it is based and when I discover the facts and they don't coincide with your hypothetical I am going to pay very little attention to the answer. If they do, then it may be of some value.

All right now,will you put it.

MR. TOBIAS: Yes. Perhaps I could put two or three questions, sir, to give us some background as to what it is I am talking about.

Q Can we agree obviously that in a hospital setting there are events which happen which are routine,there are events that happen that are more critical, require more precise action on

the part of the staff, and I think that is obvious, can we agree on that?

A. Yes.

Q. All right. And I would assume from my limited knowledge of what goes on in a hospital that one of the most critical times is when a patient has gone into cardiac arrest and you are attempting to resuscitate that patient?

A. I would agree.

Q. Can we agree that at that particular time while that resuscitation effort is ongoing, the conduct of the staff members, both doctors and nurses, has to be absolutely under control?

A. Yes.

Q. And they have to exercise their best professional judgment. Do you agree with that?

A. Yes.

Q. And is it also not critical if the resuscitation effort is going to be successful that they work together collectively as a unit each having their own job and it is important that all parts of the unit function properly?

A. Yes.

Q. In fact, it is critical at that

particular time that the system worked as thought it were a well oiled machine. Do you agree with that?

A. Yes.

Q. Now, I know that from time to time any two professionals may have a genuine difference of opinion on a judgment call, and I put to you this hypothesis. During a resuscitation effort, if a doctor calls for a pacemaker and if two of the nurses have a genuine and sincere difference of opinion with respect to the appropriate kind of pacemaker to bring to the doctor, is that the time while the resuscitation attempt is ongoing to in effect have a lengthy and heated debate over which pacemaker should be used?

A. I would say no.

Q. All right. And if in fact something like that transpired, would you agree with me that in that particular instance the conflict between those two people over their difference of opinion in effect prejudiced the patient?

A. It could.

Q. All right. Can you agree with this, and this is as far as I will go, that that type of conduct during a resuscitation effort is inappropriate and not in keeping with the exercise of

their best professional judgment?

A. Again, speaking hypothetically?

Q. Yes.

A. I think there can be conflicts around an arrest that can be handled without any sequelae. They may be raised, they may be dealt with after the fact. If indeed it is conflict that is interfering with the care then it is inappropriate.

Q. Would you think that when a doctor calls for a pacemaker that pacemaker should be brought to him as quickly as possible?

A. Yes.

MR. TOBIAS: I have no further questions of this witness, thank you.

THE COMMISSIONER: Thank you, Mr. Tobias. Miss Kitely?

RE-EXAMINATION BY MS. KITELY:

MS. KITELY: Mr. Commissioner, before I start, I indicated the other day that I thought there was a comment in the Communications Book or the Meeting Book to the effect that someone thought the Trayner team was jinxed, and I used that word. Having now read the originals of the books, I cannot locate such a comment and I can only assume that in the masses of other things that the witness and I

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have read over the last couple of weeks that it appears elsewhere.

I didn't mean to mislead the hearing in any way.

THE COMMISSIONER: No.

MS. KITELY: Q. Ms. Browne, can I show you these green tickets on which are written the words name, drug, dosage and times. Are those the medication tickets to which you referred on Tuesday?

/DM/ak

MS. KITELY: Mr. Commissioner, may I offer these two tickets. I don't know how their small physical space can be recorded without being lost.

THE COMMISSIONER: Our Registrar will solve that problem I am sure, if you don't mind my simply just passing the whole problem on to you. The two tickets will be, what number, Exhibit 311.

---EXHIBIT NO. 311: Two green medication tickets.

MR. KITELY: And for reference, sir, they were contained in Exhibit 305 which was Ms. Browne's summary, and in the chronological documentation they are Item No. 4, Medication Ticket.

THE COMMISSIONER: All right, thank you.

Q. Ms. Browne, on a couple of occasions during your evidence, and more specifically yesterday in response to Mr. Olah, you were asked about the frequency with which a mental health intervention might take place with reference to the nursing staff. Have you had an opportunity to reflect on the comment that you made yesterday?

A. Yes.

Q. And would you like to clarify what you said?

A. I believe yesterday in response to how often that request would be made from nurses, the question was put to me, would that be highly unusual and my response at that time was, yes. In reflection I would correct that by saying that it would be unusual but not highly unusual.

Q. And would you see a request from the staff for that kind of counselling as a positive sign by the staff?

A. Yes.

Q. Now yesterday towards the end of the day there was some questions with respect to feeding bottles.

A. Yes.

Q. And I just want to take you, Mr. Commissioner, back to Exhibit 304 which is the diagram. Am I correct that for the majority of the patients on Wards 4A/4B the bottles are prepared?

A. That is correct.

Q. And they come onto the ward on trollies.

A. That is correct.

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Q. And some of those are prepared in the Hospital and a few are prepared outside the Hosiptal?

A. Yes.

Q. But in any event they are all sealed when they arrive on the floor?

A. Yes. Those that are prepared outside are sealed in a different way to those that are prepared inside.

Q. Whether they come from inside the Hospital or outside the Hospital am I correct that the trollies are stored in Room 432?

A. I believe in Room 428.

Q. Which is just immediately next to 432?

A. Yes.

Q. And directly across from the nurses' station?

A. Yes.

Q. So if a nurse required a bottle of formula for the child for whom she was caring, it is a question of going down to Room 428 picking it up and going back to the patient's room?

A. Yes. Some of the formula prepared in Hospital is stored in the refrigerator

and that would be stored in the kitchen, Room 416, also adjacent to the nurses' station.

Q. In any event it doesn't take the time to go back to the kitchen, or the utility room and actually pour the formula into the bottle and seal it and then go down to the ward, it is just a question of - down to the room rather, it is just a question of taking a bottle off the appropriate cart.

A. That is correct.

Q. Or out of the fridge.

A. Yes, and picking up a nipple.

Q. Now, in some of your evidence you were asked about the extent to which you have an involvement in actual bedside care. Am I correct that on a daily basis you certainly don't have any involvement in administrating medications and actually caring for a child?

A. That is correct.

Q. But that it is still part of your job?

A. Yes.

Q. Am I correct that a component of your job is to accompany a child to surgery in the morning?

A. Yes.

Q. And so if an infant was scheduled you would go down with the infant, down, go into the operating room and stay with the infant or child, as the case may be, until sedation had taken effect?

A. Yes.

Q. And then you keep the parents informed during the course of the surgery?

A. Yes.

Q. And then would you maintain contact with the parents while the child was in the ICU?

A. Yes.

Q. And then follow the child from the ICU on to the ward?

A. That is correct.

Q. And amongst other things, am I correct, that when there were ward meetings that it was important for as many members of the staff to attend you would cover a certain patient load?

A. Yes.

Q. And did I understand you to say that the September 26th mortality meeting was one in which you were likely covering a patient

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assignment.

A. Yes.

Q. And am I correct that during your attendances at the Hospital five days a week you would be called upon to double check digoxin on occasion?

A. Yes.

Q. And to fill up buretrol on occasion?

A. Yes.

Q. And perhaps the call bell that you have described to go into a patient's room while somebody went to the bathroom or went and had coffee?

A. Yes.

Q. Miss Thomson outlined to you the different kinds of rounds that are available in the Hospital, and one of those was the pathology conference on Monday afternoons?

A. That is correct.

Q. And she asked you whether nurses were invited and you said, yes. She did not ask you whether nurses actually went. Am I correct that they did not usually go?

A. That is correct.

Q. That it would be the exception

if they did?

A. Yes.

Q. And the reason for that was not lack of interest but lack of time to get off the ward and got to the conference?

A. That is correct.

Q. Now, I would like to deal briefly with the question of Phyllis Trayner and Susan Nelles coming to you to talk about the deaths on the ward. Am I correct that the two of them were more or less delegated by the rest of the team?

A. I certainly felt the concerns they raised were not specific to the two of them but were more team concerns.

Q. And am I correct that the othermembers of the team were Sui Scott, an RN?

A. Yes.

Q. And Janet Brownless?

A. Yes.

Q. And Mrs. Christie, both are RN's?

A. Yes.

MR. OLAH: Excuse me, can my friend specify what time frame we are talking about?

MS. KITELY: After Ms. Brownless

joined the Hospital from September on.

MR. OLAH: Thank you.

MS. KITELY: Q. Am I correct that Sui Scott had young children and frequently left the ward first thing in the morning at the earliest opportunity?

A. Yes, so that she could get them off to school.

Q. And that she was not generally part of the morning report because Susan Nelles and Phyllis Trayner would be.

A. In terms of report it would be Phyllis Trayner who gave the report to the oncoming staff.

Q. And in terms of your contact with Mrs. Scott at the nursing station, since you were involved in the reporting you would not have a lot of contact with Sui Scott?

A. That is correct.

Q. At that time of the day?

A. Yes.

Q. And am I correct that Janet Brownless and Mrs. Christie during the period of time that Janet Brownless was there would in fact be helping the older children get up and out of bed

while the morning report was going on?

A. That is correct.

Q. So that they would not be part of the report either?

A. That is correct.

Q. And so it was what you would have considered natural for Phyllis Trayner and Susan Nelles to express concerns, that all five of them may have spoken about during the course of the evening shift?

A. Yes.

Q. If I might deal with where my friend Mr. Tobias just left off, and that is the question of conflict between Phyllis Trayner and Susan Nelles.

THE COMMISSIONER: I'm sorry, I thought it was a hypothetical question.

MS. KITELY: I'm not dealing with the hypothetical, I am dealing with the topic, sir.

THE COMMISSIONER: Oh, yes, all right.

MS. KITELY: Q. Am I correct that the nurses during the period in question spent two weeks on long nights and two weeks on long days, roughly?

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A. That is correct.

Q. And while you would not see these individuals during the evening shift on long nights, you frequently and regularly saw them in the morning before they left the ward?

A. That is correct.

Q. And then on the two weeks that they were on long days, you would of course have contact with them during the shift?

A. Apart from the weekends, yes.

Q. And I understood you to say that the conflict had come to you secondhand through Liz Radojewski?

A. That is correct.

Q. And am I correct that during the period in question that there wasn't an incident that you saw which caused you to have concerns that the conflict might have affected the professional care that they rendered to the patients?

A. That is correct.

Q. And given your exposure to them, is it fair to say that the conflict was certainly not constant or you would have seen it?

A. Yes.

Q. When Mr. Hunt was asking you

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questions the other day; Mr. Commissioner,I am referring to Volume 85 at page 8476, at the bottom of the page, a question put to you by Mr. Hunt was:

"Q. I am suggesting to you that the second thing that you told the police or piece of information that you gave them was that you were concerned about the possibility of an unbalanced person walking around up on 4A and 4B and that she wasn't noticed and you put some of the blame on yourself for not noticing the odd goings on?"

And you answered:

"That's correct."

When you were asked that question, did you notice the use of the word "unbalanced" by Mr.Hunt?

A. No.

Q. And did you in fact use the word "unbalanced"at the time that you spoke to the police in July 1982?

A. No.

Q. What was the word that you used?

A. I believe it was "stranger".

MS. KITELY: Mr. Commissioner, I have to deal with one other element of Mr. Hunt's examination of this witness, and having objected vociferously to the production of a particular statement I would like to say at the outset that by dealing with it I wish that not to be taken as an indication that I am prepared to change my position, but that Mr. Hunt's examination has put me in a position where I must address this next question to the witness.

THE COMMISSIONER: Well, anything that you say doesn't prejudice your position, except for this, that the more that statement is referred to by counsel the more difficult it becomes for me to exercise a discretion to keep it out, that's all.

MS. KITELY: I agree.

THE COMMISSIONER: So there is the problem. If half of the counsel have the statement and keep constantly referring to it it becomes a little difficult for me conscientiously to say no one else can see it, that's all. Now, the very fact that you refer to it when you have objected to it that does not - it is not a form of estopel.

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MS. KITELY: That was the point I wished to make, sir.

THE COMMISSIONER: That's all.

MS. KITELY: Thank you, sir.

THE COMMISSIONER: All right.

MS. KITELY: Q. Mr. Hunt questioned you about the passage that I have just referred to, and the question that you were asked at the time of the statement given to the police was, and I quote:

"What did you think happened up there?"

Is that correct, according to what the statement says?

A. According to what is written, yes.

Q. And do you have a recollection of what else was built into that question?

MR. HUNT: May I say if my friend is going to put part of the statement to the witness I think she should put the exact answer that was given. There has been a suggestion made by this witness, the first time to my knowledge notwithstanding that the matter was fully canvassed yesterday, that when she made the statement to the police she referred to a "stranger", and the words in the statement certainly don't make any reference to "stranger".

E13 In fact they talk about a person of this calibre which hardly refers to a stranger. So in my submission before my friend goes any further the entire portion that is under scrutiny here ought to be clearly put on the record and then dealt with.

THE COMMISSIONER: What do you say to that? It seems a reasonable request. If you are going to do that at all, if you are asking about the statement, what she did say, and what was in the statement, then obviously you have to put the question in its entirety.

MS. KITELY: In my submission I ought not to be put in that position, for this reason; my friend at length dealt with the answer to the question, and I am dealing with the question.

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THE COMMISSIONER: I am sorry, but I thought you were dealing with what was the question in the statement and what was the answer. Did I misunderstand you?

MS. KITELY: No, the question that I was trying to put to the witness was what was the question that she was asked which elicited the answer that my friend spent great detail going into on the other occasions.

MR. YOUNG: Well, we have not heard the whole answer yet, Mr. Commissioner, so I support my friend, Mr. Hunt, and I do not see how hearing more of the question and part of the answer puts us in any better position.

THE COMMISSIONER: Yes, Ms. Cronk?

MS. CRONK: Sir, I hate to muddy the waters even further, but it seemed to me that Ms. Kitely did put what is reported to be a verbatim quote to the witness and asked her if it was accurate. The witness said yes. It was the question that was put and not the answer, and in fairness, I think Mr. Hunt's position is correct.

THE COMMISSIONER: Yes. Well, I will give you an opportunity to retreat from this question entirely.

MS. KITELY: I will withdraw the question, sir.

THE COMMISSIONER: Yes, all right. Thank you.

MR. HUNT: Well, withdrawing the question really does not stop it at this stage because my friend has put to the witness that reference yesterday to an unbalanced person, to which this witness agreed was not accurate, and this witness told the police it was a stranger, when the answer that we have right in front of us clearly is to the contrary. So that it cannot just be left by withdrawing the question.

THE COMMISSIONER: No, it is the later question. It was not the first question.

MR. HUNT: No, it is the answer to the first -- the question that came later. My friend dealt with the answer first and then the question, and for the first time now to make the suggestion that notwithstanding we have dealt with this in so much detail that that is not what was said when we are all looking at it, it is not reasonable.

THE COMMISSIONER: Not all of us.

MR. HUNT: Well, some of us.

THE COMMISSIONER: Well, I am not

going to require any further elucidation. You have withdrawn the last question and I am not going to ask you to go back on the other.

MS. KITELY: Thank you, sir.

Q. Finally, if I might refer you to Mr. Young's cross examination, and again I am referring to Volume 85, page 8543. Starting at line 6, Mr. Young asked you, the question was:

"Q. All right, I will try again. Do you think that there is a possibility that this administration might have been intentional?

And the answer was:

"A. That is possible."

Using a scale of 10, Ms. Browne, where would you put the possibility of an intentional administration of digoxin with reference to the infants about which we are discussing?

MR. YOUNG: I did not hear the witness' answer, I am sorry. I did not hear the answer of the witness.

THE WITNESS: I have not responded.

THE COMMISSIONER: Well, she had not responded yet.

MR. YOUNG: Well, that would explain

it, Mr. Commissioner.

THE WITNESS: Could you clarify the scale for me, please?

MS. KITELY: Q. On a scale of 10, if 1 is the least possible and 10 is the most possible ---

THE COMMISSIONER: I would have thought zero was the least possible.

MS. KITELY: Q. You are right, sir. If zero is the least possible and 10 is the most possible, where would you place the possibility of intentional administration of digoxin?

THE COMMISSIONER: If you can answer that question I will happily turn over this job to you.

The trouble with it, though, is that you are asking about 36 babies and surely there is some difficulty in that if you are talking about general ---

MS. KITELY: Well, Mr. Young put it to her in those general terms and I do not wish to narrow it; I wish to address the general question.

THE COMMISSIONER: Yes, all right.

THE WITNESS: I guess then at what point am I responding? Am I responding to that in terms of today?

MS. KITELY: Q. Well, I would say that Mr. Young put it to you, and I am sure he will correct me, in the context of July 1982 when you were interviewed by the police?

MR. YOUNG: Well, that is wrong.

MS. KITELY: If that is not the case ---

MR. YOUNG: No, I meant today.

MS. KITELY: As of today?

MR. YOUNG: You will notice, Ms. Kitely, unlike you, I did not refer to the statement to avoid this problem. I was simply interested in the witness' best information today.

MS. KITELY: Well, we will deal with today, then, Ms. Browne.

MR. YOUNG: Or yesterday.

MS. KITELY: Or tomorrow. Today.

THE COMMISSIONER: Not tomorrow, no.

MS. KITELY: Q. In terms of today's point in time, Ms. Browne, on a scale of 10, using zero as the least possible and 10 as the most possible, where do you place the possibility of intentional administration of digoxin?

A. Intentional administration, between 2 and 3.

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Q. And Mr. Tobias asked you about your opinion with respect to natural causes in these infants. Where on the same scale would you place natural causes in terms of possibility of death?

MR. TOBIAS: Well again, Ms. Kitely, could you advise the witness what time frame you are referring to?

MS. KITELY: Q. As of today.

A. Is that reflecting on that nine month period?

Q. Those infants, yes.

A. Yes. Between 8 and 9.

MS. KITELY: Those are all my questions.

THE COMMISSIONER: That cannot be possible. That has to be between 7 and 8. You see, with 3 and 9 you come to 12, and you are only allowed 10. While I have no objection to anything else and I have no way of correcting you, I can deal with mathematical problems as long as you do not go over 10.

Now, do you want to try that again? You have got intentional 2 to 3 and natural causes 8 to 9, and it is a scale of 10.

THE WITNESS: And it does have to

add up to 10?

THE COMMISSIONER: I think it does. I really think I am going to insist on that. You are going to have to try again with those figures.

THE WITNESS: Then I would go between 7 and 8.

THE COMMISSIONER: Yes, thank you.

MS. KITELY: Those are my questions, sir.

THE COMMISSIONER: That still conceivably gets us to 11, but I will allow that.

THE WITNESS: Thank you.

THE COMMISSIONER: All right, thank you, Ms. Kitely. Ms. Cronk.

MS. CRONK: Thank you, sir.

RE-DIECT EXAMINATION BY MS. CRONK:

Q. Mr. Registrar, could you show the witness if you would, please, Exhibit 306? You will recall, sir, that that is the photograph of the intravenous apparatus that was marked by my friend, Ms. Kitely.

Ms. Browne, I would like to direct your attention to the total number of injection sites which appear to be outlined on this photograph and the captions which accompany the photograph. As I

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look at the exhibit, I see three and potentially four sites at which a drug could be injected into any part of the IV apparatus; is that correct?

A. That is correct.

Q. And the first is an injection site directly into the intravenous bag itself?

A. Yes.

Q. The second and potentially third are sites located below the drip bulb on the IV tubing?

A. Yes.

Q. You have indicated there is one shown on the photograph, but there is a possibility that there could actually be two sites at that location?

A. Yes.

Q. Then finally there is a third, at least on this photograph, injection site further down on the IV tubing but not yet near the point of entry to the patient; do I have that correctly?

A. On this picture?

Q. Yes.

A. Yes. Well, it is near the point where the IV tubing connects the tubing to the patient. Is that what you are referring to?

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Q. All right. Am I correct as well, Ms. Browne, that it is also possible to inject a medication directly into the buretrol?

A. Yes.

Q. And that is not shown on this photograph?

A. That is right, it is not.

Q. That would be a fourth injection site?

A. Fourth and potentially fifth.

Q. Fourth or potentially fifth injection site?

A. Yes.

Q. And on your normal IV apparatus would there not be an injection site directly into the buretrol as there is on the exhibit that has been marked here?

A. Yes.

Q. Is it as well possible to inject a drug directly into the site on the patient's skin or body where the IV apparatus is connected?

A. A few inches from the needle.

Q. Could you please show the Commissioner where that is.

A. It would be right here by

disconnecting.

Q. All right, and once you have disconnected the tubing from what you described earlier as the butterfly needle and the tubing to which it is connected, how would one then physically administer a drug at that site?

A. By disconnecting, you then would connect this to the syringe, not a needle but to the syringe itself.

Q. So you would remove virtually the entire IV apparatus save for the connecting part which you have directly attached to a syringe?

A. Yes.

THE COMMISSIONER: I think we have to describe that a little better. That is called a butterfly needle at the end?

THE WITNESS: Yes.

THE COMMISSIONER: And it has attached to it, what is it?

MS. CRONK: Q. Approximately two inches of IV tubing.

A. Yes, it is just fine tubing.

THE COMMISSIONER: And then there is a connection. Is that described -- it is not described. Is that part of the butterfly needle,

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would it be called, that little connection to the tubing?

THE WITNESS: It would since it is one piece.

THE COMMISSIONER: Apparently you are saying that you could insert the syringe in ---

THE WITNESS: You would connect the syringe directly to this.

THE COMMISSIONER: Is that done sometimes?

THE WITNESS: Occasionally, yes.

THE COMMISSIONER: Yes, all right.

MS. CRONK: Q. And that is a fifth, potentially sixth injection site which appears on a standard set of IV apparatus?

A. Yes.

Q. All right, thank you. On the question of medication administration generally, Ms. Browne, as I understood your evidence, you told Ms. Kitely that any intravenous digoxin must be administered according to the Nursing Manual at the Hospital for Sick Children by a physician and that that was so whether it was to be administered above or below the drip chamber on the intravenous apparatus; did I understand that correctly?

F-12

A. That is correct.

Q. Do I have that correctly, as well, Ms. Browne, that that was the actual practice, as you understood it, on Wards 4A/4B rather than the practice or policy reflected in the Nursing Manual?

A. Yes.

Q. Indeed, so that we are clear, Section 18.01 of the Nursing Manual specifically provides that a registered nurse could add medications to the vacolitre or the IV tubing above the drip bulb or pedatrol on an IV apparatus?

A. That is correct.

Q. The Standards of Nursing Practice that you reviewed both with me in your evidence in-chief and with Ms. Kitely laid down by the College of Nurses specifically provide that one of the basic skills of a registered nurse is the preparation and administration of intravenous medications above the drip chamber?

A. That is correct.

Q. Are we then in the position that although the Hospital's Nursing Manual permitted it and the College of Nurses Regulations and Standards of Practice permitted it, your evidence is

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that registered nurses on Wards 4A/4B did not administer medications, specifically digoxin intravenously at any place on the IV line?

A. That is correct.

Q. Most certainly they did orally?

A. Yes.

Q. Am I further correct that drugs other than digoxin were administered intravenously by registered nurses on Wards 4A/4B so long as they were administered above the drip bulb with buretrol?

THE COMMISSIONER: All right, I thought that that exception applied to some other drugs besides digoxin?

THE WITNESS: It does. It also applied to valium and Dilantin were the exceptions to what could be added above the drip chamber.

MS. CRONK: Quite right, sir, thank you.

Q. There are, then, I take it, drugs with which registered nurses on Wards 4A/4B could administer intravenously so long as they did it above the drip bulb or above the buretrol?

A. That is correct.

Q. So that it would not be

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unusual, I suggest to you, on Wards 4A/4B to see a registered nurse near an IV apparatus with a syringe in hand for the purposes of administering a medication?

A. That is correct.

Q. That would not be regarded as unusual be the nursing staff on duty?

A. No.

Q. Could I ask you to turn to the Ward 4A communication book, if you would. That is in Exhibit 300. That is the bound volume of books.

The Ward 4A communication book is under the first tab, and I would ask you to turn to page 30. Do you have that, Ms. Browne?

A. Yes.

MS. CRONK: Sorry, sir, the first tab, page 30.

THE COMMISSIONER: Yes, thank you.

MS. CRONK: Q. Item 2 on this page, Ms. Browne, is part of an entry made on January 14, 1981 and it reads, at least it appears, I would suggest, to be a direction that the parenteral Inderal supply was to be used for oral supplies of Inderal in emergency situations.

To the best of your knowledge was that the practice in emergency situations on Wards 4A/4B after January 14, 1981 with respect to

E-15

Inderal?

A. Yes.

Q. Was that also the case in March of 1981, as you understand it?

A. Yes. That is page 31.

THE COMMISSIONER: Yes, I think it is page 31. I was so busy working on the page that I missed your question. What was the question?

MS. CRONK: If we now have the right page --

THE COMMISSIONER: Yes.

MS. CRONK: -- item number 2 reads, and I have suggested to Ms. Browne and I think she has agreed that it is a direction that parenteral, that is intravenous Inderal supply be used in emergency situations for the oral administration of Inderal.

THE COMMISSIONER: Yes, all right.

MS. CRONK: Q. And Ms. Browne has told us that to the best of her knowledge that was the situation both in January 1981 and in March 1981 on Wards 4A/4B; have I restated that correctly?

A. Yes.

Q. Could we turn, then, to another area, Ms. Browne. You will recall perhaps that yesterday Ms. Thomson, counsel for the Hospital,

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referred you to the notes contained in the Ward 4A meeting book concerning the meeting held during the evening of October 23rd, 1980; do you recall that?

A. Yes.

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Q. All right. And she asked you why specifically there would be feelings of frustration expressed by the nurses at that meeting given that the deaths on Wards 4A/4B in September and October of 1980 had decreased and were lower than the number of deaths that had occurred over the two summer months of July and August. Do you recall that?

A. Yes.

Q. And as I understood the line of discussion she asked you whether there was anything specific that had occurred which gave rise to a concern or frustration at that time, that is, October 23rd, and I believe you indicated no there wasn't, to the best of your knowledge?

A. That is correct.

Q. Do I have that correctly?

A. Yes.

Q. All right. You will recall Ms. Browne there were 10 deaths on Wards 4A/4B during the months of July and August, 1980?

A. Yes.

Q. And as Ms. Thomson suggested to you, there were then two more in the month of September and three more in the month of October,

G.2

indeed, by the very day, October 23rd, there had been three more in the month of October. Do you recall that discussion?

A. Yes.

Q. Am I correct then that by October 23rd, 1980, the day of that meeting, there had been 15 deaths on Wards 4A/4B in something a little less than a four-month period?

A. That is correct.

Q. I suggest to you that that was a most unusual death rate in the history of those two wards?

A. Yes.

Q. All right. And I suggest to you as well that although the number of deaths in September and October were less dramatic perhaps than had been the case in the months of July and August there was certainly good reason for the nurses to believe on October 23rd that the trend was continuing. Would you agree with that?

A. Yes.

Q. All right. And I suggest further that a very specific concern had been raised by nurses the day before the October 23rd meeting, that is, that on October 22nd a very specific concern had

G.3

been raised concerning the death of Antonio Adamo. Do you recall that?

A. Yes.

Q. All right. And specifically I would ask you to turn to the Ward 4B meeting book which is Exhibit 301, sir, at my page 7. Am I correct, Ms. Browne, that on October 22nd there was a meeting amongst four nurses from Ward 4B at which they specifically discussed Antonio Adamo's arrest several days earlier and the reaction of Ward 4A nurses to that arrest?

A. Yes.

Q. All right. And was it not also proposed on October 22nd that a meeting be held as soon as possible to discuss the arrest generally and to discuss patient consultations?

A. Yes.

(2) Q. All right. And then a meeting was in fact held the very next day, October 23rd, at which the arrests were discussed?

A. Yes. That was an evening meeting?

Q. That's right.

A. Yes.

Q. And in fact the Ward 4B meeting book and the page to which I have drawn your attention

G.4

suggests that two Ward 4A nurses were blaming themselves for the death of Antonio Adamo. Is that correct?

A. Yes.

Q. And it was attempted was it not at a meeting on October 23rd by the nurses present to reassure those nurses who felt that the arrests might have been their fault?

A. Yes.

Q. I suggest to you that those two reasons alone provided a very specific impetus for a meeting on October 23rd, that is, the total amount of 15 deaths in something less than four months what was perceived to be a continuing trend in the deaths and very specific concern over Antonio Adamo's death, isn't that correct?

A. Yes.

Q. I would like to draw your attention as well very briefly to Exhibit 305, Mr. Registrar, if you would, please.

A. Could I ask what that is?

Q. Yes, I'm sorry. It is the summary that you prepared.

A. Thank you.

Q. I would ask you to turn to the

G.5

last page if you would, Ms. Browne, that is the page entitled routine for administration for drugs. Do you have that?

A. Yes.

Q. All right. And your discussion with Ms. Kitely when this exhibit was introduced, it was suggested to you that this page if you will sets out the nine steps from start to finish that a nurse goes through in administering any drug, and I believe you acknowledged that that was correct. Do I have that correctly?

A. Yes.

Q. May I suggest to you first, Ms. Browne, that this routine does not apply to the administrationof any drug because most clearly it does not apply to narcotics which are controlled drugs. Is that true?

A. Not specifically. That's true, yes.

Q. Well, this routine does not in fact reflect the routine that is required to be followed if you are administering a narcotic or a controlled drug, does it?

A. That is correct.

Q. All right. And, secondly - well,

perhaps fairly I should ask you this. I take it that these nine steps are those which in your opinion reflect the routine that was to be followed for the administration of digoxin on Wards 4A/4B prior to March 22nd, 1981?

A. It doesn't specify the double checking by another RN.

Q. I was just coming to that. Leaving that aside for the moment, do I have it from you that according to your understanding that is the procedure that applied for the administration specifically of digoxin on those wards before it became a controlled drug?

A. No, it is not specific in that it doesn't specify the double checking.

Q. All right. And by the double checking are we referring to the factor that a second nurse had to be fetched if you will or requested by the first nurse to come and check the calculation and the dose?

A. That is correct.

Q. All right. I am interested Ms. Browne, in precisely what the function of the second nurse is in that situation? First, was she to check the calculations of the first nurse who was

G.7

drawing up the drug?

A. Yes, she would do her own calculations and then compare so that she wouldn't repeat any errors that the first nurse made by just going through that same process.

Q. Did she did her own set of independent calculations?

A. That is correct.

Q. All right. Was the second nurse required as well to check the amount of the dose and the type of the drug against the medication card just as the first nurse was required to do?

A. Yes.

Q. All right. Was the second nurse required to actually observe the drug being drawn up?

A. Yes.

Q. She was actually required to be physically present when the first nurse drew the drug up?

A. Yes.

Q. Were there instances on Wards 4A and 4B of which you are aware where on occasion a nurse who was about to administer a drug brought a syringe filled with the drug toether with the medication ticket and the broken vial from which the drug had been obtained to a second nurse to be checked?

A. It was not a broken vial if you will, it was a bottle of medication that she would draw from or a small bottle with pills in it.

Q. All right. You are talking then about oral administrations?

A. Yes.

Q. All right. And was it, to the best of your knowledge, possible on those wards that in some situations the first nurse who had prepared the drug would have already inserted the drug in the syringe prior to showing it to the second nurse who was to check it?

A. I can't recall instances of that from my experience.

Q. Thank you, that's helpful.

A. Okay.

Q. And was it also a function of the second reviewing nurse, if you will, that she was to physically observe the administration of the drug?

A. The actual giving of the drug to the patient?

Q. Yes.

A. No.

Q. I take it then that in theory

G.9

at least it would be possible that although a drug had been drawn up by Nurse A and checked by Nurse B that there would not necessarily be a guarantee that that was in fact the drug that was administered?

A. In that Nurse B did not witness that drug being given, that's correct.

Q. That's a possibility?

A. Yes.

Q. So that the second reviewing nurse would not necessarily be in a position to attest in a positive way that the drug that she had checked was the drug that in fact was given to the patient?

A. That is correct.

Q. And can you help me as well with reference to the list that is before you, the summary of the routine? First of all, that whole procedure of the involvement of the second nurse is not reflected on this list?

A. That is correct.

Q. All right. Nor is there, as I read it, an indication that the first nurse who draws up the medication must record the fact that the medication has been given, that's not on the list?

A. No, that needs to be No. 10

and I apologize for that omission.

Q. Well, please understand, this is in no way critical, I am just trying to understand what other steps there are in the process. No. 10 I suggest is the involvement of the second nurse who reviews the drug and checks the calculations and I am now suggesting that there is another one and, that is, that in the normal case when a drug is being administered the nurse would also have to record that she in fact had administered it?

A. That is correct.

Q. All right. We have heard about four medication errors involving digoxin which occurred on Wards 4A/4B during the months of October and November, 1980. You may recall that according to the Ward 4B Communications Book it appears that three of those errors took place in October; one on October 6th, one on October 10th, and one on October 15th, and I ask you simply to accept those dates from me.

A. I remember them well, yes.

Q. All right. And the fourth, according to the Communications Book, happened on November 7th, 1980. Do you recall that?

A.

Q. I am showing to you, Ms. Browne, what I understand to be the incident reports that were filed at the Hospital in respect of those other errors. Starting first with the error on October 6th and then following chronologically through to November 7th. I would ask, sir, that that be marked as the next exhibit.

THE COMMISSIONER: They are all together, so, that will be Exhibit 312.

--- EXHIBIT NO. 312: Incident Reports.

MS. CRONK: Thank you.

Q. I would ask you first, Ms. Browne, if you would to look at the very first patient incident report and I note, Mr. Commissioner, simply for the purpose of the record, that I have deleted the patient names from these incident reports although they are contained on the originals.

THE COMMISSIONER: None of these of coursse are children with which we are concerned?

MS. CRONK: None are our children, sir.

THE COMMISSIONER: All right.

MS. CRONK: I'm sorry, that may not be read properly in the future. None are the 36 children with whose deaths we are concerned, bearing in mind fortune cookies.

G.12

Looking at the first patient incident report, Ms. Browne, dated October 6th.

THE COMMISSIONER: We should have a heading for "In Jokes".

MS. CRONK: Yes, I'm sorry, sir.

Q. Looking at the first patient incident report dated October 6th, 1980. Contrary to what is suggested in the Communications Book and the description of these errors, I suggest to you that the nature of this incident was not an extra dosing involving digoxin at 9 a.m. but rather an extra dose was given at 2100 hours when it should have been held. That's the nature of the incident, isn't it?

A. That is correct, yes.

Q. All right. But then if we look at the other three incident reports, the other two that took place during the month of October and the third - I'm sorry, the fourth and final one which took place in November, I suggest to you that as in fact is set out in the Communications Book, each of these errors involved an extra dose of digoxin being given at 9 a.m. when a dose had already been given at 5:30 a.m. on the same day. Am I correct?

A. That is correct.

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Q. All right. And having regard to the fact, Ms. Browne, and I ask you to accept this from me, that none of these incident reports involved any of the 36 children whose deaths this Commission is concerned with. I take it that in not one of these four cases was the result of the medication error a fatal result, none of these children died?

A. Not that I know of, yes.

Q. I would like to discuss for a moment if I may generally the issue of incident reports with you, Ms. Browne.

THE COMMISSIONER: I wonder, if you are close we will carry on, if you are not we will take a break.

MS. CRONK: Sir, I would like to take a 10-minute break if that would be convenient to you.

THE COMMISSIONER: Well, it probably wouldn't be convenient to everybody else because they can't do it. But I suppose that's fine as long as you and the witness can come back in 10 minutes we will take a 10-minute break.

MS. CRONK: Well, I certainly can, sir, and I will take it upon myself to see that Ms. Browne does.

THE COMMISSIONER: How long do you think you will be?

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MS. CRONK: About 15 minutes, sir.

THE COMMISSIONER: Yes, all right, we will take a 10-minute break.

--- Short recess.

/DM/ak

---Upon resuming.

THE COMMISSIONER: Yes, Miss Cronk?

MS. CRONK: Thank you, sir.

Q. Ms. Browne, I would like to return briefly to the matter we discussed before the break. You will recall I asked you whether or not to the best of your knowledge there were situations which might arise on Wards 4A/4B where a nurse preparing a medication would have actually placed the medication in the syringe before she took it to the second nurse whose duty it was to check the drug. You told me that that might happen in the situation of an oral medication or oral administration, do I have that correctly?

A. Yes, although I have not witnessed that.

Q. I am interested as well because as you have told us there are situations in which registered nurses on those wards administered medications intravenously, although not to the best of your knowledge digoxin. In those situations to the best of your knowledge is it also possible that the nurse who drew up the medication to be administered intravenously could have filled the syringe from the intravenous vials before taking it to the second

H2

registered nurse to be checked; I take it that is a possibility as well?

A. I'm having just a little trouble with your question.

Q. All right.

A. Would you go back to the beginning part of it please.

Q. Certainly. I am talking now of a situation involving an intravenous medication as opposed to an oral dose.

A. Okay, so we are talking about the drip chamber?

Q. Yes, we are.

A. Thank you.

Q. And I am talking as well about the nurse who actually draws up the medication. I am suggesting to you that it is possible that there would be situations where the nurse in preparing the medication were to break open the intravenous ampule, draw up the drug into the syringe and then take the syringe with a broken ampule to the second nurse for the purposes of having the dose and the drug checked, is that a possibility?

A. Well, are we talking digoxin here?

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Q. No, we are talking about those drugs which could be administered intravenously.

A. Okay, which would be anti-biotics and that kind of thing and they were not routinely checked by another nurse.

Q. I see. So do I have it then that the drugs which were administered on Wards 4A/4B intravenously by registered nurses were not subject to a second check by a second nurse?

A. Apart from narcotics.

Q. Apart from narcotics and controlled drug?

A. Yes.

Q. Thank you, Ms. Browne. We were discussing as well the issue of incident reports. Can you help me first as to the circumstances in which, as you understand it, a nurse on Ward 4A/4B would be required to file an incident report, what type of matter was required to be reported?

A. If there was any error made in treatment and medication, that might be ommission, or it may be related to the actual administration, be it time, dose, patient.

Q. And indeed that relates to the provision that we saw the other day in the nursing

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manual which requires medication errors to be first reported to the head nurse or the nurse in charge; and secondly, requires the preparation and filing of an incident report.

A. That is correct.

Q. Are there situations other than drug errors which form the subject matter of an incident report? To help you with that, perhaps you could look at the incident reports that we just filed, the four related to the drug errors in the months of October and November. I suggest to you that incident reports cover a wide variety of matters apart altogether from drug or medication errors.

A. That is correct.

Q. For example, one could be filed in respect of an accident involving a patient, and indeed there is a specific portion of the form designated for completion if it is an accident that is being reported?

A. That is correct.

Q. And that could properly form the subject matter of an incident report?

A. Yes.

Q. For example, if a child fell

H5

out of bed an incident report might be filed.

A. That is correct.

Q. If the child was hit by another child that could form the subject matter of an incident report?

A. Yes.

Q. If an unexpected mark or bruise was detected on a child an incident report should be filed?

A. Yes.

Q. If at the end of any particular procedure conducted in the patient's room it was found that there was a particular instrument missing, or that there was an inaccurate count done of the instruments left in the room, that would require the filing of an incident report I suggest.

A. Yes.

Q. In short, the total number of incident reports filed for Wards 4A/4B during the months July 1980 to March 1981 would not I suggest reflect in any way the total number of drug errors on those two wards during that nine month period?

A. That is correct.

Q. And that would be true as well

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of the Hospital at large if we looked at the total number of incident reports in the Hospital for that nine month period?

A. Yes.

Q. You told Ms. Forster yesterday, or the day before as I recall it, that following the relocation of the Cardiology Wards to Wards 4A/4B transfers of patients to the Intensive Care Unit was sometimes delayed, do I have that correctly?

A. That is correct.

Q. And I take it you were referring to the transfer of patients from Wards 4A/4B to the Intensive Care Unit?

A. Yes.

Q. And as I understood your evidence you further indicated that the occupancy rate in the Intensive Care Unit was up following the relocation of the Cardiology Wards?

A. Yes.

Q. And you further indicated that to the best of your knowledge children were leaving the Intensive Care Unit too early on occasion?

A. On occasion.

Q. Ms. Browne, during the period July 1980 to March 1981, did any member of the

H7 nursing staff on Wards 4A/4B ever suggest to you that there was difficulty being experienced in having patients from Wards 4A/4B transferred to the Intensive Care Unit?

A. Concern about their transfer?

Q. Was it ever suggested that there was difficulty being experienced in arranging for the transfer of a patient from 4A/4B to the Intensive Care Unit?

A. Yes.

Q. Do you recall specifically what patients were involved?

A. No, I don't.

Q. Are you certain in your own mind that that difficulty was raised with you during that nine month period by a member of the nursing staff on those two wards?

A. Yes.

Q. Do you know who raised the issue with you?

A. No.

Q. Can you help me as to when the matter was raised?

A. Not specifically, no, but it would be around a nursing concern that a child was

very sick and needed additional assistance that they couldn't provide and felt it was best provided in Intensive Care.

Q. My concern, Ms. Browne, is this: do you have a general impression that there was difficulty during that nine month period in arranging for transfers of patients into the Intensive Care Unit, or do you have a specific recollection that it was a matter raised as a problem and discussed?

A. There were certain situations where that was a difficulty and it was discussed.

Q. But you have no recollection and can't provide me with any particulars as to when it was discussed, by whom or what patients were involved.

MR. OLAH: Or perhaps how many times it was discussed; or how many times the matter arose.

MS. KITELY: Q. Do you recall whether it arose on more than one occasion?

A. More than one occasion but I would have difficulty saying how many.

Q. On what basis, Ms. Browne, did you similarly form the impression that children

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were leaving the Intensive Care Unit too early during that nine month period of time?

A. In part it was based on my nursing observations of their progress in Intensive Care because I did see them daily. It was also related to the nursing concerns in providing care for that child on the ward, and that sometimes would necessitate a request for a relief nurse because of there needing to be more closer observation of that on the ward.

Q. You are aware I take it, Ms. Browne, of the identity of the 36 children that are of concern to this Commission, you have heard their names.

A. I have heard the names, yes.

Q. Were any of those children at any time the subject of a discussion by you with any member of the nursing staff wherein it was suggested that one of those children had been transferred back to the ward too early from the Intensive Care Unit?

A. I don't think I can say.

Q. You don't recall one way or the other?

A. No.

Q. Do you have any specific recollection today at all of that having been a problem with respect to a particular patient on Wards 4A/4B during that nine month period of time?

A. Not specifically.

Q. Could I return to the former issue, that is the transfer of patients from Ward 4A/4B into the Intensive Care Unit, and again bearing in mind the identity of the 36 children with whom we are concerned, did any of those children insofar as you can now recall it present any difficulty or pose a problem in terms of their transfer into the Intensive Care Unit?

A. I am sorry, I can't say specifically from memory.

Q. I take it, Ms. Browne, that if the Intensive Care Unit was experiencing a bed shortage, for example, which might necessitate premature transfer of a child from the Intensive Care Unit back to the ward, that one of the options that might be available would be the transfer of that particular child to another area of the Hospital where intensive monitoring might be available?

A. That is correct.

Q. And for example, if the child

Hll

involved was a neonate the transfer might in fact be from the Intensive Care Unit to the Neonatal Ward as opposed to back to Wards 4A/4B?

A. That is correct.

Q. We have heard a fair amount in the last several days about constant care and your understanding of the concept as it applied on Wards 4A/4B. During the 9 month period with which we are concerned again July 1980 through to the end of March 1981, did any member of the nursing staff every indicate to you that a request for constant care on Wards 4A/4B had been made either by a physician or a head nurse that could not be accommodated by the available nursing staff on those wards?

A. There were situations where it couldn't be accommodated by the existing nursing staff but in those situations relief staff was obtained.

Q. Was there any situation every brought to your attention where a physician had requested or directed constant care and it was unable to be provided due to staff shortages or for any other reason?

A. Not that I am aware of, no.

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Q. Yesterday I believe you were asked by Mr. Labow whether or not Phyllis Trayner and Susan Nelles had worked together on Ward 5A prior to the relocation of the Cardiology Wards to Wards 4A/4B?

A. Yes.

Q. Phyllis Trayner testified at the Preliminary Hearing, Ms. Browne, and this evidence is found, Mr. Commissioner, in Volume 3, page 633, it is a very brief passage. She was asked this question, Ms. Browne:

"Q. All right. When did you first meet Susan Nelles?

A. Hm?

Q. Approximately?

A. I think it was in September of 1979.

Q. September 1979. Where was she at that time?

A. She had just moved down to 5A.

Q. From where?

A. 6A.

Q. And did you work with her when you were on 5A?

A. Periodically we did, we weren't on, we were not on the same

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"team at that time but we would run into each other on off days."

Does that evidence accord with your understanding of the situation as it applied on Ward 5A prior to the relocation of the Cardiology Wards at the beginning of April 1980?

A. Yes.

Q. Do I have it correctly then that insofar as you are aware the first time that those two nurses worked together as a team was following the transfer of the Cardiology Wards to 4A/4B?

A. Yes.

Q. Can you help me as to who assigned the various teams on Wards 4A/4B after the relocation?

A. It was two head nurses.

Q. That would be Elizabeth Radojewski and Mary Costello?

A. Yes.

Q. And are you familiar with the basis upon which the decision was made to assign those teams?

A. No.

Q. Do you know whether the teams

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that existed on Wards 5A were preserved following the relocation insofar as possible?

A. There was some attempt at that but the staff split between the two wards at the beginning.

Q. And I take it that the time of the relocation of Wards 4A/4B was the time when Susan Nelles was assigned to Phyllis Trayner's team?

A. I believe so.

Q. With respect to the nursing teams on Ward 4A/4B there is some confusion in my mind at least, Ms. Browne, as to what the burden of your evidence has been over the last several days concerning the matter of splitting up a team, or teams on Wards 4A/4B and I would like to be very clear about this.

As I understand it, perhaps I should put the question to you; was the issue of splitting up a nursing team on Wards 4A/4B essentially concerned with the splitting up of Phyllis Trayner's nursing team, or did you understand it to be a larger issue than that?

A. The issue affected all of the teams if there would be any change in one team as perceived by the nursing staff. I believe the

H15

comments that were made yesterday were related to that specific team and relocating it.

Q. Opposed to the comments that were made yesterday, is it your understanding, and I appreciate that any change in the composition of any particular nursing team would necessarily involve a change in at least one other team to accommodate that?

A. Yes.

Q. Is it your understanding that the dicussion regarding the splitting of nursing teams centred around the division of Phyllis Trayner's nursing team?

A . Yes.

Q. One final area and that one concerns Amber Dawson. You will recall that Mr. Shanahan yesterday on behalf of the parents of Amber Dawson asked you a series of questions with respect to that child. You will recall I believe that you told us that the nursing staff had specific concerns regarding the timing and the cause of death of Amber Dawson, do I have that correct?

A. That is correct.

Q. I would ask you to turn to page 6 of Ward 4A communications book. Under the

first tab, sir, of Exhibit 300, that is, it may be your page 7, it is my page 6.

We have looked at this page before, Ms.Browne, and you will recall that prior to August 8th an entry had been made in the communications book indicating that there was an element of surprise concerning the cause of death of Amber Dawson. Then on August 8th, 1980 we see the entry that a post mortem had been conducted and that it showed an abscess on the diaphram, that the coroner had communicated with the mother of Amber Dawson and that a full report could within two months time. To the best of your knowledge, did the nursing staff accept the abscess on the diaphram of this child as an explanation for her death?

A. Yes.

Q. Were concerns ever again expressed to you after August 8, 1980 by any member of the nursing staff concerning the cause of that child's death?

A. Not that I recall.

Q. Do you recall it ever being raised with you by a physician after August 8th?

A. No.

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Q. Were you aware, Ms. Browne, that the pathologist who completed the post mortem autopsy report on Amber Dawson had indicated that it was not possible to determine an anatomical cause of death for that child?

A. No.

Q. That wasn't a matter that ever formed a discussion between yourself and any members of the nursing staff on Wards 4A/4B?

A. No.

Q. You were asked yesterday to elaborate, and indeed it arose again this morning, on the nature of what was suggested to you was a conflict which had existed between certain members of the Phyllis Trayner nursing team, do you recall that discussion?

A. Yes.

Q. I suggest to you, Ms. Browne, that part of that conflict, concerns specifically a dispute over the calling of a Code 25 during the arrest of Amber Dawson. Did that issue, the nature of a dispute of that kind ever form part of the nursing concerns that were expressed to you regarding that child's death?

A. Not that were expressed to me, no.

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Q. Do you recall any physician ---

MR. BROWN: Mr. Commissioner, there was no way that I could object to the question the way that my friend phrased it. I would certainly prefer in the future that the witness be asked in more general terms about her personal knowledge relating to any incident that might have happened affecting any nurse, and then if she does recall a particular incident, that can be brought out. But the way the question is phrased, it is impossible.

THE COMMISSIONER: Yes, I agree, Mr. Brown. If it is possible, since the answer was negative that she did not know anything about it, but we could have avoided all the exercise Mr. Brown is getting, that could have been avoided if you had put it that way.

MS. CRONK: I understand that, sir, and I gave some thought to the framing of the question, and I will not belabour the point before you, but I am not prepared to agree that I am so restricted unless you -- the matter has been pursued.

MS. CECCETTO: Well, Mr. Commissioner, this witness testified yesterday and was asked specifically by Mr. Brown to comment on the competence of Susan Nelles, and she was also asked to comment on the competence of Phyllis Trayner.

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It seems to me that if she is not aware of major points of conflict, that casts some doubt on her assessment.

THE COMMISSIONER: Yes. Well, there you are getting some support. However, the answer was that you did not know anything about this particular incident, I take it?

THE WITNESS: That is correct.

MS. CRONK: From any member of the nursing staff?

THE COMMISSIONER: Well, you did not know anything about it until today?

THE WITNESS: No, that is correct.

MS. CRONK: No, I am sorry, sir, that is not really the question I put to the witness.

What I asked her was whether or not a member of the nursing staff had ever raised that kind of an issue with her concerning the arrest of that child, and I was about to ask her whether it was ever a matter of discussion between the witness and a physician, a cardiologist on the ward.

THE COMMISSIONER: You understand that Mr. Brown's point is that all you have to say is that there was apparently -- did you ever hear anything about some incident that took place between nurses

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at the time of Amber Dawson's death?

MS. CRONK: I understand his point, sir.

THE COMMISSIONER: That is all.

MS. CRONK: I understand his point, sir.

THE COMMISSIONER: And the answer would have been no, I think it would have been no. Would it have been no?

THE WITNESS: That is correct.

THE COMMISSIONER: Then you would not have had to go on any farther and we could have saved -- that is all I am saying, we could have saved -- probably it is good for Mr. Brown to get up and down like that, but we would have saved that incident.

MR. YOUNG: Well, Mr. Commissioner, I ---

THE COMMISSIONER: You do not want to save it either.

MR. YOUNG: I am just a little confused. For the future are we not allowed to help the witnesses refresh their memories, if indeed we know about the circumstances.

THE COMMISSIONER: Certainly.

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MS. CRONK: That is precisely the point, sir.

MR. YOUNG: I mean, I intend to do that, Mr. Commissioner.

MS. CRONK: It seems to me, sir, and I did not intend to ---

THE COMMISSIONER: Well, it will not be a problem after the New Year. It is only a problem today, the 22nd of December, but after the New Year we will be so close to this particular problem, maybe, depending on what the Divisional Court does that it will not be a problem any more. I am merely just trying to avoid problems today, the 22nd of December.

MS. CRONK: With that undertaking, sir, I will leave the matter entirely.

THE COMMISSIONER: So, everybody is on your side except Mr. Brown and me.

MS. CRONK: Well, it is the undertaking that counted, sir, and I am prepared to go on.

THE COMMISSIONER: Okay.

MS. CRONK: Q. One final area, Ms. Browne, and it arises out of your evidence this morning.

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Can you help me as to when you first learned of the digoxin levels that were recorded concerning Janice Estrella?

A. I cannot say specifically. It was some time late March, early April.

Q. 1981?

A. Yes.

Q. When did you first learn, as best you can recall it, of the digoxin levels recorded on Kevin Pacsai?

A. It would be the same time frame.

Q. What about the digoxin levels on Justin Cook?

A. Again that same time.

Q. Do you recall when you came into work on Monday, March 23rd whether you were made aware at that time of the digoxin levels that had been obtained on Justin Cook?

A. I do not believe so, no.

Q. Finally, do you recall when you first became aware of the digoxin levels that had been recorded at the hospital concerning Allana Miller?

A. I do not recall, no.

Q. But I take it that with respect

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to Janice Estrella, Kevin Pacsai and Justin Cook, as best as you can recall it, it was some time in the month of March or April, 1981?

A. Yes.

Q. You told Mr. Tobias this morning, as I understood it, that at the end of March 1981 you thought the deaths that had occurred on Wards 4A/4B could be explained by natural causes; did I understand that correctly this morning?

A. Yes.

Q. And you have said previously in evidence that as at July 9, 1982, 1982 --

A. Yes.

Q. -- you expressed the opinion that you found difficulty in accepting the fact that all of those deaths could be fully explicable by natural causes; do you recall giving that evidence as well?

A. Yes.

Q. Can you help me, Ms. Browne, as to what happened between the end of March 1981 and July 9, 1982 which caused you to alter your opinion?

A. A whole lot.

Q. Well, help me specifically with what happened.

A. Certainly information that came through the hospital about ---

MR. TOBIAS: I am sorry, Mr. Commissioner, I am having a great deal of difficulty hearing the response.

THE COMMISSIONER: Yes, all right.

MS. CRONK: Q. Information from the hospital that ---

A. It was certainly information from the hospital about digoxin levels and then certainly there was a good bit of information that came out in the press following the preliminary.

THE COMMISSIONER: Following which?

THE WITNESS: The preliminary.

THE COMMISSIONER: Oh yes.

THE WITNESS: That spoke very specifically to digoxin levels.

MS. CRONK: Q. Anything else that you can recall now?

A. Not that I can recall.

Q. When you refer to information from the Hospital concerning digoxin levels, you have told me that you knew about Estrella's, Cook's and Pacsai's digoxin levels in or about March or April of 1981. So I take it that over the succeeding

months there was nothing new with respect to the levels themselves that came forward that caused you to change your opinion?

A. No, I think it was looking at that over time.

Q. It was rather your considering what the significance of those levels was?

A. Yes.

Q. Was that not a matter you considered in your own mind when you first heard about it?

A. Not seriously, I do not think. It was disbelief at that time.

Q. Do I have it, then, that once the information as to the actual digoxin levels was made available to you and you had time to reflect upon them, you came to the conclusion that these deaths could not be explained by natural causes?

A. I questioned whether indeed it was natural causes.

Q. And you had, based on that consideration and that reflection of those levels, difficulty in accepting that the deaths were due to natural causes?

A. When I was asked to speculate

about that.

Q. I am not asking you to speculate, Ms. Browne. I am asking you now what your opinion was after you had time to consider the matter.

A. Would you ask the question again, please?

Q. What I am suggesting to you is that after the information about the digoxin levels was made available to you and you had an opportunity to reflect upon them and to consider their significance, was it then your opinion that the deaths of those children could not be -- you had difficulty accepting that the deaths of those children could be explained by natural causes?

A. I had difficulty explaining how a digoxin level came to be so high.

Q. So that we are clear, did you not, as well, express the opinion that you had difficulty accepting the fact that their deaths could be explicable by natural causes?

A. Yes.

MS. CRONK: Thank you very much. I have no further questions.

THE COMMISSIONER: Thank you, Ms. Cronk.

MS. CRONK: Thank you very much, Ms. Browne.

THE COMMISSIONER: If no one else has anything, we will -- yes, Mr. Brown?

MR. BROWN: As usual, I do have something. If I could perhaps ask, through you, a question of Ms. Cronk, and that is if she could give us some guidance on the schedule of witnesses in the new year.

MS. CRONK: The present scheduling is such, Mr. Commissioner, that we anticipate that Dr. Mirkin will be recalled commencing January the 10th. I have been woefully wrong in the past when I estimated the length of evidence, but I think with some certainty you can say that he will be here that entire week. If the scheduling changes on that, of course, we will advise counsel as soon as possible.

THE COMMISSIONER: Mr. Lamek is back there, but I think the probability is that he will be around for two weeks. You can tell us, Mr. Lamek, if you will what you plan after that.

MR. LAMEK: First of all, Dr. Mirkin, I expect in the week before he is called to have a final report from him. I have not got it yet. As soon as I have it, I propose to distribute it to

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counsel, and I hope that does not ruin anybody's vacation in the first week of January. If it does, so be it.

We will start with Dr. Mirkin on Tuesday, January 10th. It is my expectation that he will carry through into the next week, and it would not surprise me greatly if he took all of the three days that remain in the week of the 16th.

I then propose to call the Atlanta authors on the week of the 23rd, and I have every expectation that they may find themselves here for more than four days as well.

MR. BROWN: When you speak of the Atlanta authors, what witnesses are you referring to?

MR. LAMEK: I am arranging for all four of the signatories to be here, and I have to speak to you again, sir, about the possibility of calling them in a gaggle, as it were.

THE COMMISSIONER: Yes, all right. Well, we will have to consider that, I guess.

MR. LAMEK: But that occupies January, I think.

THE COMMISSIONER: Yes, all right. Well then, until the 10th, which is the Tuesday, at 10 o'clock, we will meet again, and in the meantime,

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of course, for everyone, the usual comments about Merry Christmases and Happy New Years, and we will meet again after those events are over.

---witness withdraws.

---Whereupon the hearing adjourned at 12:15 p.m. until 10:00 a.m. Tuesday, January 10th, 1984.